BY HAND DELIVERY

Southwest Catholic Health Network

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March 25, 2008

Michael Veit
Contracts and Purchasing Section
Arizona Health Care Cost Containment System
701 East Jefferson, MD5700
Phoenix, Arizona 85034

Re: AHCCCS RFP No. YH09-0001

Dear Mr. Veit:

Southwest Catholic Health Network Corporation, dba Mercy Care Plan ("MCP") believes there are significant flaws in the actuarial methodology and assumptions that underlie the AHCCCS CYE '09 Acute Care RFP (No. YH09-0001) ("the RFP"). It is our hope and intention that these issues can be discussed pursuant to A.A.C. R9-22-602(B)(3) & (4) allowing them to be resolved through the RFP process itself. It is our understanding this would allow AHCCCS to "initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal" and to discuss "the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state."

As described in greater detail below, MCP is concerned that (1) the Maricopa County reinsurance offsets (at the $20,000 deductible level) are priced too high, (2) AHCCCS has made no "incompletion adjustment" to its encounter data used to develop pricing, and (3) the RFP is unfair to incumbent plans, such as MCP, with higher need existing patient populations. The cumulative effect of all of these problems is to call into question (1) the methodology to be used by AHCCCS to evaluate capitation rate proposals, and (2) it places MCP at a competitive disadvantage to other offerors. Indeed, we believe that these errors would mean that the capitated rates would not be actuarially sound in violation of 42 C.F.R. § 438.6(c).

1. Reinsurance

As several potential bidders (including MCP) have noted in several questions, data indicates that the reinsurance offsets (at the $20,000 deductible level) appear to be priced too high. This is especially true for Maricopa County where the average CYE09 reinsurance offset increased 59% over CYE08 for TANF rate cells. Yet in our evaluation, the data does not support such a large increase. For example, the TANF 1-13

CYE09 offset reflects an increase of 205% to $5.31 over CYE08, but the total reinsurance claims over the previous three years do not justify any such increase. Total reinsurance claims for this cell were only $2.62, $2.47 and $1.93 in CY04, CY05, and CY06 respectively. Even with very generous trend and completion factors, and ignoring the outlier effect altogether, the reinsurance offset is over-priced.

The effect of this issue is significant. MCP estimates that to bid with these reinsurance "overages," it would need to increase its bid price by 1.8% or alternatively forfeit all projected profit. New offerors may assume that the reinsurance offsets are accurate and make no such adjustments. Given the stipulation in the RFP on scoring capitation proposals, the result will be that these offerors' bids will score higher despite the fact that they may be presenting unrealistic bids.

When this issue was raised by several potential bidders (including MCP), AHCCCS responded that reinsurance offset was based on reinsurance data and trends from CYEO4 through CYE06, which have historically trended high as a result of the effect of outlier claims, demographic changes, and the leveraging effect of a fixed deductible. This trend, however, is misleading unless correctly adjusted at the rate cell and member case level. Furthermore, the mere existence of historically high reinsurance claims does not imply that future trends will continue at this pace. Large, reinsurable claims for CYE07 have been on a much slower pace than previous years, implying a negative reinsurance trend from CYE06 to CYE07. And for CYE08 and CYE09, the outlier program change will reduce the otherwise expected rate of increase in large, reinsurable hospital claims.

Relief requested: That AHCCCS take another look at the reinsurance offsets. In particular, we suggest the following methodology. First, AHCCCS should parse historical and projected inpatient claims into "reinsurance eligible" inpatient claims and "non-reinsurance eligible" inpatient claims. Second, AHCCCS should subtract the reinsurance offsets from projected total inpatient claims (using total inpatient trend and subtracting $37.3 million for the CY09 outlier impact). AHCCCS should then look at the implied trend for "non-reinsurance eligible" inpatient claims. MCP believes the remaining implied inpatient trend is inadequate and not what AHCCCS intended. After this exercise is completed, MCP requests that AHCCCS reevaluate the reinsurance offsets such that all three trends are consistent (total inpatient trend, reinsurable inpatient trend, non-reinsurable inpatient trend).

2. Encounter Data

Every state Medicaid program reports one or more problems with its encounter data that result from the failure to capture completely all claims incurred. For example, state encounter data can be incomplete as a result of provider settlements, encounters not passing all state edits, simple human error, et cetera. To account for these problems, most states and their consulting actuaries estimate and add an "incompletion factor" (not

related to adding traditional incurred-but-not-paid reserves). MCP is concerned that AHCCCS determined that an "incompletion factor" was not needed after comparing encounters to "booked" financial data that was not truly on a "run rate" basis.

Yet, our analysis indicates that there were potentially significant encounter problems. The Introduction of "Section C – Databook Information" in the bidders library states, "One health plan was excluded from all databooks due to encounter data issues. AHCCCS believes it is in the best interest to exclude this health plan data, and its exclusion does not materially impact the data or resulting rate ranges."

This admission by AHCCCS has two important implications. First, this confirms that there are indeed problems with encounter data submissions that would justify the use of an incompletion factor. Here, AHCCCS decided to exclude one plan's encounter data altogether as a result of this problem. It is likely, however, that there are also many less obvious issues (such as those discussed above) related to all plans in the AHCCCS program that have not been taken into account. Second, the exclusion of an entire plan's encounter data itself raises concern. This plan may have had different-than-average risk. It is also unknown how "material" is defined in this, or any other situation. Some consider 1% "not material"; but to many Medicaid plans, this is the difference between profitability and loss.

Relief requested: That AHCCCS evaluate the capitation rate ranges after applying an actuarially sound incompletion factor or alternatively add additional points to the upper bound of the capitated rate ranges by rate code to account for these uncertainties.

3. Adverse Selection

We are a provider sponsored, mission driven nonprofit entity dedicated to serving the poor and disadvantaged, and because of our mission and network, more high need patients have chosen MCP. According to AHCCCS data, our members in Maricopa County have about a five percent higher cost than the average AHCCCS population. Unfortunately, it appears from both the RFP and AHCCCS' subsequent written answers, that MCP will be treated unfairly in the scoring of its capitation proposal as a result of the increased risk of their existing patients resulting from adverse selection.

According to the RFP (at p. 75), AHCCCS does not anticipate even developing a risk adjustment methodology to deal with this adverse selection problem until April 1, 2009—a full six months into the contract year. The RFP makes it clear that AHCCCS "will apply no more than 50% of the capitation rate adjustment to the *remaining months* of the contract year." *Id.* (emphasis added). And, in its written responses to questions, AHCCCS said that it does not intend to apply the risk adjustment methodology retroactively. [Response to Question 132, Responses 2/29/08] AHCCCS has compounded this problem by stating that "Bidders should not adjust for the impact of risk

adjustment when building the capitation rate bids." [Response to Question 175, Responses 2/29/08]

MCP did not raise this issue during the RFP question process for two reasons. First, raising this issue would have provided other bidders pricing information relevant to MCP. Second, until the February 29, 2008 responses, MCP was hopeful that this issue would be resolved by the risk adjustment described in the RFP and in AHCCCS' scoring of capitated proposals.

Given that it has a population of high need patients, MCP must include the reality of its existing risk into its capitation rate proposal. Failing to do so would mean the actual risk of its patient base during the first six months of the contract year would never be taken into account since the first risk adjustment will not occur until April 2009—and only then on a prospective basis. We therefore request that AHCCCS take the reality that some plans have high need patient populations into account in scoring the capitated rates and in setting the range of acceptable capitation rates.

Unless this is changed, the RFP will have failed to provide an even playing field for all competitors. It will penalize MCP for serving a higher need patient population. Simply put, a fair scoring of proposals requires that the needs of the different patient populations be taken into account to assure an "apples-to-apples" comparison.

Relief requested: That AHCCCS take the needs of the actual patient populations into account in scoring the capitated rate proposals and that it also set the capitated rate range such that plans with patient populations with high needs are not penalized.

Conclusion

MCP believes that each of these issues can be addressed by AHCCCS by making adjustments to its capitation scoring methodology, by raising these issues with all offerors during the normal process, or by making amendments and allowing appropriate revisions to offeror pricing (perhaps as part of the BAFO process). Alternatively, AHCCCS could retain the present March 28 deadline for the technical proposal but extend the deadline for the capitation proposal until such time it is confident that it has resolved the data issues. This would allow the RFP process to proceed, while still giving AHCCCS time to address all of these data issues.

These are very serious issues, however, that need to be addressed if the procurement process is to be fair and legal. Accordingly, if (and only if) AHCCCS believes that these issues cannot be resolved by discussions that AHCCCS will have with all offerors during the procurement process, please consider this letter to be a formal protest of the RFP under A.A.C. R9-22-604. While we hope that such a step is unnecessary, please understand that we are following AHCCCS procurement rules that require any concerns with the RFP to be presented before any responses are due.

Pursuant to A.A.C. R9-22-604, if this is treated as a protest, the protestor's name, address, and telephone number are as follows:

Southwest Catholic Health Network Corporation
dba Mercy Care Plan
4350 E. Cotton Center Blvd., Bldg D
Phoenix, Arizona 85040
(602) 453-8315

The RFP number is AHCCCS RFP No. YH09-0001. The signors of this letter are representatives of the protestor. The legal and factual basis of this protest and the relief requested is provided above.

Again, we believe that the normal bid process offers an appropriate avenue for all of these issues to be addressed, and hope AHCCCS will choose to use the normal bid process rather than the bid protest process for resolution.

Very truly yours,

Stanley Aronovitch,
President and CEO
Mercy Care Plan

Linda Hunt
Chair, SCHN Board of Directors
President, St. Joseph's Hospital & Medical Center

c: Chuck Blanchard

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